TESTIMONY TO THE WHITE HOUSE CONFERENCE ON AGING
SOLUTIONS FORUM ON RURAL AGING
WEST VIRGINIA UNIVERSITY CENTER ON AGING
MAY 2005

I am Richard J. Ham, MD. For the past three years of my 36 years as a physician, I am proud to have been Director of the host organization for this WHCOA Solutions Forum: the WVU Center on Aging; so welcome, officially, to West Virginia!

I am a past president of the American Geriatrics Society, primary editor of a standard text - now in its fifth edition - in the primary care literature of my field, and as a clinician and educator, my emphasis for the last 20 years has been on the recognition and management of one of the most challenging problems for our elders and those who care for and about them: Alzheimer's and the other dementias, and the many illnesses which complicate and imitate them.

I am one of approximately 10 geriatricians (physicians trained and specializing in health care of the elderly) in WV, most of us clinician educators rather than researchers. None of us could support ourselves financially by direct health care of elders alone (even if we wished to do so). Recruitment to careers devoted to caring for the elderly continues to suffer greatly because of this financial aspect i.e. the limitations of the reimbursement for "evaluation and management" and counseling and education through Medicare and Medicaid, relative to the complex and ongoing care needs – in diverse practice sites - of a high proportion of elders and their families. Another set of barriers are attitudinal: care of elders is seen as relatively drab and unexciting – attitudes fostered by our acute care, high technology after the event, "save a life", "rescue the sick from the jaws of death" approach, reflected in a payment system that tends to pay readily and well (sometimes too well) for procedures, but underpays for the thoughtful working through of many concurrent problems, of individual decision making in these, the most individually unique of all the patients whom doctors encounter. In fact, good geriatric medical care requires a "cutting edge" attitude, constantly updating oneself, using the latest technology, both for therapy and for investigation, and the newest evidence, much of it *non*-medication evidence ; our field is challenging as it is in a constant state of change in terms of what is ethical and reasonable to do in any one circumstance, as the possibilities of modern medicine expand at an unprecedented rate. To ensure that ultimately *all* health professionals can practice adequate geriatric health care, enthusiastic, experienced and skilled role models are needed. The need for good teachers and teaching of health professional sin this vital area, long relatively neglected in health professional education has become very urgent, so that we can respond to "the geriatric imperative".

GERIATRICS

"Geriatrics" is used here to mean "health care of the elderly" as used by the AGS and various medical boards. It is an area of medicine, which has been defined and redefined in these past few decades, which includes not only the care of the already frail and the

prevention of unnecessary dependency, but also the primary prevention of some of the problems of the old, generally by an approach that at least begins in younger adulthood and often in childhood and adolescence, e.g. osteoporosis. This is the best example of the necessity of adopting a lifelong approach in this field. Osteoporosis, once regarded as a "normal aging" change, is now recognized as a potentially *preventable* problem – primary prevention through education in high school and then by good health habits (habits which have many other benefits) throughout adult life (exercise, diet rich in calcium, vitamin D and good protein, restricted alcohol and caffeine, no smoking etc), and yet still *treatable* when it is already present (and still too often overlooked because it is so common as to be "normal"), with many secondary and tertiary preventive methods - of proven impact - when it is already present (e.g. preventing falls by increasing balance skills and adjusting the environment with lighting and flooring etc, medications to increase bone strength, and nutrition that includes the good protein, vitamins and calcium essential to bone health at any age). In these ways, hip fractures (1 in 3 women and 1 in 6 men will sustain a hip fracture by the age of 90) and other terrible consequences of osteoporosis *could* be prevented by education and implementation of good health habits throughout life. The education needs to start in elementary school!

RURAL ISSUES

A huge portion of those living in rural areas are elderly, mostly because of out migration of the young to find work. There is thus a rural elderly population with the following known characteristsics:

1. prejudice and embarrassment about brain symptoms of any kind (e.g. rural dementia patients are presented for medical care later than non rural)
2. more poverty and near poverty, with no money for good food, nor money to pay out of pocket for services that are known to enable frail elders to stay longer in their own homes)
3. less work force available (less younger people in general, including families and paid assistants) to provide hands on care
4. less family and less social network in some cases, for informal support and to replace unavailable but essential services such as transportation and shopping
5. less services available close enough to help (senior centers, chore services, in home nursing, etc.)
6. lack of transportation (effects health care, social support, nutrition etc.)
7. generally less education, most significantly about healthy lifestyles and the treatable nature of many changes formerly accepted as "normal"
8. decreased health literacy (a huge problem in all signets of the population, but especially in elders, and especially in rural elders, and their families; actual illiteracy is increased - and often unrecognized) too
9. culturally different: proud, independent - both the resulting from rural life and the reasons why many choose to live away from urban areas, resulting in being…
10. unwilling or frankly unable to access hospital care or emergency services, and…
11. unwilling - often - to access or accept services seen as "welfare"

12. increased unwillingness to consider as medical illness, any problem seen as "mental illness" (including dementias and depression, two of the most frequently unrecognized major problems for elders in any setting)
13. often living in relatively unsafe and unsuitable housing, without the resources to fix the familiar environment in which most prefer to "age in place"

All of the above result in (references are available) a population of elders with:

14. more disability than non-rural elders,
15. more obesity, and thus…
16. more diabetes mellitus type 2 (DM), and thus..
17. (probably) more dementia and…
18. more vascular disease, amputations, renal failure, legal blindness, and all the other terrible potential consequences of DM.
19. less good nutrition (many consequences) and
20. less health maintenance and disease prevention in general (a problem in all older persons of all backgrounds, but in addition, for rural elders, if the doctor, nurse etc. are inaccessible, why go when you're "well"?)
21. less accessible skilled nursing facilities (SNFs – nursing homes) and the alternatives to them, for the more dependent, less healthy people, often unwilling to even *be* "patients," who are the end result of all the above factors

HEALTH PROFESSIONAL TRAINING

Geriatrics is still underemphasized in medical and other health care professional (HCP) training and continuing education.

Most HCP's never see rural life and practice during the formative years of their training (they often barely see anything outside the hospital setting.) Many barriers exist to changing this pattern of education, including faculty resources, expense, accommodation, etc.

Many solutions to the above omissions have been demonstrated, many as a result of private initiatives and philanthropy (e.g. the Hartford and the Reynolds foundations), and many from federal initiatives (e.g. the Geriatric Education Centers) and state initiatives (e.g. WV's Ruaul Helath Educational Partnerships – RHEPs - see below; started in part by the Kellogg foundation), yet they cannot be implemented and sustained in the smaller schools that train most HCPs (and often cannot be sustained in the schools that demonstrated their impact!) (many references available).

RURAL HEALTH CARE PROFESSIONALS

In most rural areas there is a federally recognized physician shortage. However, the many other health professionals needed to practice minimally adequate geriatric medicine, not only to increase efficiency of physician care but also as disciplines which, if absent, result in *no* service being available (e.g. physical therapy, dental care, social work)

Many MDs are FMGs - trained and raised in a different culture. Some adapt beautifully to the needs of the populations they serve, but often communication is a problem - pronunciation, terms used, etc. This is a problem for US graduates too! All HCPs must be aware that "rural" is an ethnicity and a culture in itself.

To best serve rural elders, cultural competence can and must be taught to HCPs in practice and in training. We are doing this in WV…

WEST VIRGINIA SOLUTIONS

Some examples of how these issues are being addressed in West Virginia are:

1. WVSENIORS – A website that lists all available services, by community and county, and by type of service, to which we have added much public and HCP education. This is accessed through libraries and senior centers, and about half of its use is by HCP support staff themselves as a source of information. Families and patients themselves can and do access the site themselves, along with our caregiver-specific site, WVCAREGIVERS.

2. PUBLIC EDUCATION through West Virginia Public Broadcasting – both public TV and radio - plus columns in the local press for each area.

3. RHEPS (Rural Health Education Partnerships) - A network of groups of HCPs and and other health and service providers, with paid site coordinators. Students from medicine, nursing, pharmacy and dentistry trained in West Virginia are obligated (state law) to attend this experience e.g. MD/Dos rotate for two months at these "real life" sites. This helps recruitment and retention of HCPs for rural areas.

4. AGES (Advanced Geriatrics Educator Skills) an annual exam and diploma for practicing physicians, physicians assistants and nurse practitioners - to encourage, implement and recognize being up to date in our changing field.

5 GEMS (Geriatrics Educators of the Medical schools of WV) - All three medical schools in WV work together on common issues including AGES and the forming of the West Virginia Geriatrics Society.

6. MSGEC (The Mountain State Geriatric Education Center) – A vital, federally funded program that fosters interdisciplinary training in geriatrics which has brokered and demonstrated many of our geriatric educational initiatives (full descriptions available).

7. A PACE and a clinical, specialized center for geriatric care for our largest (and needy) urban area, Charleston, the state's capital. This is in the advanced planning stage, but is wholly dependent on federal funding (PACE) and local private philanthropy (the geriatric care center) as well as support from the state and WVU..

RECOMMENDATIONS

To prevent the impending crisis in health and health care in rural America, I recommend the following solutions:

1. Continued support for the Medicare Chronic Disease Management Act. This bill will enable comprehensive care and coordinated management to be provided for elders with 5 or more chronic diseases, or dementia and 1-2 chronic diseases. It is the best hope we have that Medicare will at last be modified to match up to the medical/health care needs of this nation's frail elders, and their families.
2. Support and encouragement of research funding to foster the development of incentives for industry to sponsor trials and then to implement the use of technology for the home bound and those with limited mobility.
3. Federal (NIH, NIA, CMMS, HRSA et al) research funding to measure:
    A. health outcomes of innovative educational initiatives.
    B. a campaign, carefully evaluated, with outcome measure built in from the start, of public education, including revision of the required School Health curriculum, promoting a lifelong approach to making old age a less dependent, more attractive period of life than it currently is and is seen to be, and to promote a more positive attitude to aging and the aged themselves
    C. a comparable initiative for all health professionals, in training and practice, including required certification and update for all HCP's in the well define curriculum of geriatric medical care (references to this available)
4. Support for the ongoing, permanent funding and expansion of the network of GEC (Geriatric Education Centers) by HRSA, which for years have encouraged and implemented the very type of care sought to be reimbursed under the Medicare Act described above.
5. Incentives for state organizations (Medical Societies, AGS chapters, DO groups, Social Work and Nursing associations) to include and encourage ongoing involvement and focus on the elderly, *including the special needs of rural elders.*
6. Support for demonstration projects and subsequent implementation incentives for overcoming the lack of public, volunteer, faith-based or private transportation availability in rural areas.
7. Increased availability of mental health care in rural areas.

The list is incomplete; the unmet needs - ultimately a cost burden to all of us – of rural elders are many and varied. More ideas, from a range of national experts are in our 2004

publication for the AOA: “Best Practices in Service Delivery for the Rural Elderly” (downloadable from www.ruralaging.org).

Respectfully submitted,

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